New Hampshire Primary Care and Maternal & Child Health Services 1996-2002

A Report Utilizing Uniform Data System (UDS) Tables

New Hampshire Department of Health and Human Services

Division of Public Health Services

Bureau of Community Health Services

Maternal and Child Health Section

New Hampshire Primary Care and Maternal & Child Health Services, 1996-2002

A Report Utilizing Uniform Data System (UDS) Tables

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February 2005

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MESSAGE FROM THE COMMISSIONER

Primary Care is an important element to health and wellness. We know that access to physician and nursing services both reduces costs and improves health outcomes. As we work to improve the health of the citizens of New Hampshire, we need to find ways to encourage the use of Primary Care and prevention.

The Community Health Centers of the state offer high quality Primary Care to many who would otherwise lack access to care. Many of the uninsured, as well as those who use Medicaid, use these services to receive high quality care at reasonable rates. These centers provide an important link in the continuum of health care in New Hampshire.

I would like to thank the Division of Public Health Services for this report. The staff has again displayed their excellent ability to provide information that accurately reflects the health of the state and provides both areas of strength and improvement.

John A. Stephen, Commissioner
New Hampshire Department of Health and Human Services

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ACKNOWLEDGEMENTS

The Maternal and Child Health Section wishes to acknowledge the community-based health care agencies listed in Appendix 1, for collecting and reporting data on their clients.

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EXECUTIVE SUMMARY

In 1994, a steering committee composed of representatives from the major national public health organizations adopted a list of ten essential public health services (Harrell, J.A. & Baker, E.L.). One of the services determined to be essential was "linking people to needed personal health services and assuring the provision of health care when otherwise unavailable". In New Hampshire, the Division of Public Health Services (DPHS) fulfills this core function, through the Maternal and Child Health Section (MCH) and the Rural Health and Primary Care Unit (RHPC). DPHS administers federal and state funding intended to improve the availability of, and access to, preventive and primary health care for all individuals, regardless of ability to pay.

This report focuses on the services provided by the DPHS through a statewide network of community-based, non-profit, safety-net agencies. These services target underserved people who face barriers to accessing health care, such as lack of insurance, inability to pay, geographic isolation, and cultural and language issues.

In calendar year 2002, these agencies *provided health care services to 80,761 clients*, *a 25% increase* over the seven-year report period, 1996-2002. This figure is approximately 5% of the population of New Hampshire, evidence that *a significant percentage of residents rely on these publicly funded services*. The number of low-income individuals served increased by 9%, to 44,142. The number of uninsured individuals decreased by 11%, to 32,603, although this decrease occurred only in categorical agencies. Community Health Centers (those agencies that provide comprehensive primary care services) served 6% more uninsured individuals in 2002 than in 1996. The decrease in uninsured clients in categorical agencies may be due, in part, to an increase in children or pregnant teen clients enrolling in the Healthy Kids Program.[1] Clients who became covered under this program shifted from uninsured to "Medicaid" or "Private Insurance" in the data presented in this report. Additional contributing factors may have been: agencies having an increasing need to reach out to insured populations, in order to maintain fiscal viability; and the strong 1990's economy, with its resulting jobs.

Many other changes seen during the period are consistent with the growth and development of primary care agencies, including *an increase in serving older individuals*, clients for whom affordable health care may not have previously been available or accessible. Changes in the NH population over this time period likely affected agency numbers. For example, over the 10-year period, 1990 to 2000, the population increased by 11.4%, and the percent of citizens living below the Federal Poverty Level increased by 14%. The largest increase in percent living in poverty during the 10-year period occurred in children under 18 (54%).

[11] The New Hampshire Healthy Kids Corporation, which administers the State's Title XXI Children's Health Insurance Program (CHIP), made health insurance more accessible to low income children in January of 1999. Through Healthy Kids Gold, formerly referred to as Medicaid, eligibility for infants expanded from 185% to 300% of the federal poverty level, with coverage for children 1 through 18 years being up to 185%. Healthy Kids Silver, which provides health insurance with premiums based on income, became available for children ages 1-19 that are 185%-400% of the poverty level. The Healthy Kids Corporation estimates that, within its first fifteen months of operation, CHIP reduced the number of uninsured children by one third (NH Healthy Kids Quarterly Report, 1st Quarter, 2000).

While changes have occurred in agency structure and client caseload mix, it is clear that these agencies continue to provide health services for many vulnerable citizens in need throughout the state. In 2002, *over half of the clients served by these public health agencies lived in households with incomes less than 185% of the Federal Poverty Level*. *Seventeen percent utilized Medicaid for health insurance and an additional 40% were without insurance of any kind*. Without the safety-net services provided by these publicly-funded community-based agencies, increasing numbers of low income and uninsured residents would be left without health care.

REFERENCE

Harrell, J.A. and Baker, E.L., The Essential Services of Public Health. *Leadership in Public Health 3(3):27-31, 1994*

I. INTRODUCTION

A. BACKGROUND

In 1994, a national steering committee composed of representatives from the major public health organizations adopted a list of ten essential public health services (Harrell, J.A. & Baker, E.L.). One of these essential services was "linking people to needed personal health services and assuring the provision of health care when otherwise unavailable". In New Hampshire, the Department of Health and Human Services (NH DHHS), Division of Public Health Services (DPHS), fulfills this core function through the Maternal and Child Health Section (MCH) and the Rural Health and Primary Care Unit (RHPC). DPHS administers funds intended to improve the availability of and access to preventive and primary health care for all individuals, regardless of ability to pay. Through the provision of health care services statewide, the DPHS seeks to reduce disparities - in access to health care and in health outcomes - that currently exist between different racial and ethnic groups, between people of different socioeconomic levels and between those with and without health insurance.

This report focuses on services funded, through MCH, by the federal Maternal and Child Health Block Grant (Title V of the Social Security Act) and the State of New Hampshire. This funding helps support community-based health care agencies in the provision of health care services for all ages, with an emphasis on women, infants, and children. These non-profit safety-net agencies may have other public and private sources of funds as well, from organizations such as United Way and others. Services provided by the agencies include direct health care, as well as case management, nutrition, social services, home visiting, transportation, and language interpretation services. The locations of the agencies assure that most services are available throughout the state. In addition to providing needed health care services, these agencies are also quite successful in integrating public health and prevention into clinical practice, providing true population-based care. (see Appendix 1 for a list of agencies)

This report is based on information from agencies that report to MCH via the Uniform Data System (described below). While previous analyses of data collected from these agencies have been used for internal planning purposes, and for providing feedback to the agencies, this report represents the first time that these data have been compiled for public use.

B. DATA SOURCE

The federal Uniform Data System (UDS) tables have been used since 1996 by MCH to collect data from funded agencies. These agencies are funded either as Community Health Centers (CHCs), delivering the full range of services to all age groups, or as categorical agencies, providing one or more of the following categories of health care services: prenatal care, family planning or child health. The UDS tables were adopted, in part, so that MCH data collection from federally funded Community Health Centers would be consistent with federal reporting requirements, thus reducing the burden of paperwork. The reporting system includes information about the number of clients served, insurance status and income, and thus provides basic, but invaluable information about program activity and the clients served.

At the time the reporting system was adopted, MCH was collaborating with several agencies in their transition from the provision of categorical services to comprehensive primary care for all populations. During calendar year 2002 there were eight Community Health Centers and eighteen categorical agencies reporting via the UDS tables. Because the two types of agencies deliver different types of services, and operate differently as well, they are separated out for this analysis. For example, a primary care center can bill a managed care organization (MCO) for services provided, since they can deliver all the services required to do so, e.g. 24-hour medical coverage. A stand-alone child health program - e.g. an agency providing well-child care, but not primary care services - cannot bill an MCO, and therefore may serve fewer insured clients.

The major limitation of the UDS tables is that they are discrete, not allowing for any cross tabulation or sophisticated analysis. For example, we know the number of children served and the number of uninsured clients served, but we cannot determine the number of uninsured children served. Steps are being taken to improve and refine the data collection process.

This report presents the UDS data by examining trends during the period 1996 through 2002. It is organized into three main sections: an introduction, frequently asked questions, and the main body of the report (findings and conclusions) – as well as notes, resources, and appendices. The findings are organized by:

- Client Caseload
- Clients by Age and Gender
- Low-income Clients (below 185% of the federal poverty level)
- Clients by Payment Source

REFERENCE

Harrell, J.A. and Baker, E.L., The Essential Services of Public Health. *Leadership in Public Health 3(3):27-31, 1994*

II. FREQUENTLY ASKED QUESTIONS

A. WHAT IS THE UNIFORM DATA SYSTEM?

The Uniform Data System (UDS) was designed for use by federally designated community health centers, and was adopted and modified by the New Hampshire Maternal and Child Heath Section (MCH). The New Hampshire reporting system consists of aggregate data reported annually (by calendar year) to MCH, by health care agencies with whom the Section contracts.

B. WHAT IS THE MATERNAL AND CHILD HEALTH BLOCK GRANT?

The US DHHS, Health Resources and Services Administration (HRSA), provides funding to states for the purpose of promoting and improving maternal and child health nationwide, under Title V of the Social Security Act. The NH Maternal and Child Health Section (MCH) administers the funding and contracts with community agencies to provide primary care, prenatal care, child health, and family planning services.

C. WHAT IS THE FEDERAL POVERTY LEVEL (FPL)?

The Census Bureau uses a set of income thresholds, which vary by family size, to determine who is living in poverty. If a family's total income is less than that family's threshold, then that family, and every individual in it, is considered to be living in poverty. The poverty thresholds do not vary geographically, and they are updated annually for inflation using the Consumer Price Index. While the thresholds in some sense represent families' needs, the official poverty measure should be interpreted as a statistical yardstick rather than as a complete description of what people and families need to live. Moreover, many of the government's aid programs use different dollar amounts as eligibility criteria.

For the purposes of this report, “Low Income Clients” are considered to be at or below 185% of the FPL. In most cases, this means someone is eligible for Medicaid. In 2002, 185% of the FPL, for a family of four, meant that income was less than $32,653 per year.

D. WHAT ARE COMMUNITY HEALTH CENTERS, AS USED IN THIS REPORT?

Community Health Centers (CHCs) are those community-based, non-profit agencies funded by MCH that provide primary care services, i.e. comprehensive preventive health care and 24-hour acute care, to all populations. See list in Appendix 1.

E. WHAT ARE CATEGORICAL AGENCIES, AS USED IN THIS REPORT?

Categorical agencies are those funded by MCH that are not Community Health Centers; and that have one or more of the following programs: family planning, well-child, and prenatal. The target population for these categorical agencies is, understandably, women of reproductive age and children. See list in Appendix 1.

F. WHAT IS THE DEFINITION OF CLIENTS, AS USED IN THIS REPORT?

Clients are unduplicated individuals who had at least one encounter (visit) during a calendar year. Federal UDS tables call them "users".

G. WHAT IS THE DEFINITION OF CASELOAD, AND PERCENT OF CASELOAD, AS USED IN THIS REPORT?

An agency's caseload is simply the number of *unduplicated* clients served during a calendar year. *Percent of caseload*, e.g. uninsured: divides the number of uninsured clients during a calendar year by the total number of clients.

H. WHAT ARE "HEALTHY KIDS" AND "S-CHIP"?

The New Hampshire Healthy Kids Corporation (NHHK) administers the New Hampshire State Child Health Insurance Program (S-CHIP), including outreach and coordination. Healthy Kids Gold expands Medicaid coverage for infants from 185% of the FPL to 300% of the FPL. Children ages 1 through 18 who are between 185% and 300% of the FPL are eligible for Healthy Kids Silver, which includes payment of a premium.

III. FINDINGS

A. CLIENT CASELOAD

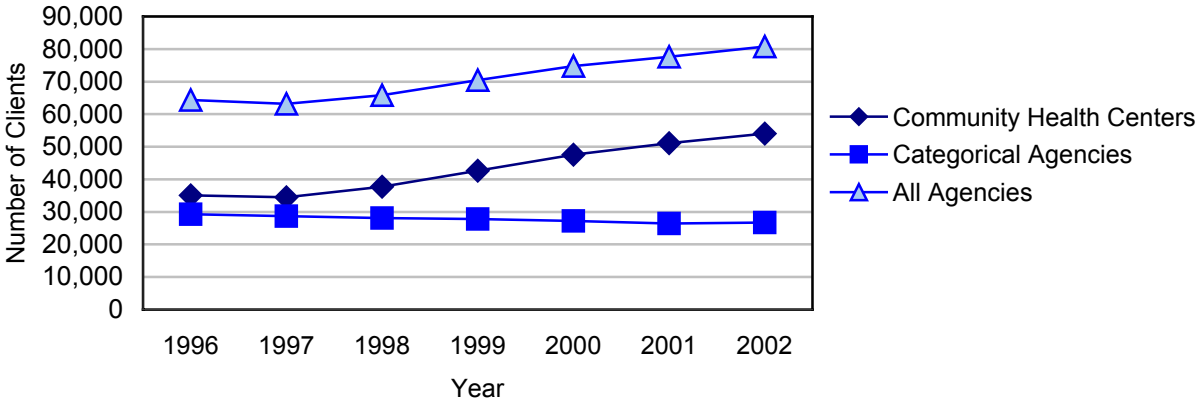
The continued need for affordable and accessible primary care services is demonstrated by the large overall increase in the number of clients served at Community Health Centers during this seven-year period, 1996-2002.

- The total number of clients in 2002 was 80,761. Community Health Centers served 54,023 clients, while 26,738 were served at categorical agencies.
- The total caseload for all agencies increased 25% over this time frame. This was an increase of 16,408 individuals.
  - The increase in caseload for Community Health Centers was 54% (18,901).
  - The categorical agency caseload decreased by 9% (-2,493) during this time.

Table 1 - Client Caseload (number of clients)

	1996	2000	2002	Percent Change 1996-2002
All Agencies	64,353	74,790	80,761	25%
Community Health Centers	35,122	47,594	54,023	54%
Categorical Agencies	29,231	27,196	26,738	-9%

Graph 1 – Number of Clients



The large increase in primary care clients is, at least in part, due to the Department's considerable commitment to transitioning agencies to primary care, and the State's commitment to providing the resources that enabled expansion of services at the beginning of this report period (there was one Community Health Center in 1995, and eight in 2002). In addition, the Department provided support to community-based providers that helped them procure significant federal funds. Another factor was that the population of New Hampshire and the number of people below 100% of the FPL in NH increased between the 1990 census and the 2000 census, by 11.4% and 14% respectively.

B. CLIENTS BY AGE AND GENDER

Agencies served an increasing number of older individuals during this time period, coinciding with the transition to, and expansion of, primary care.

Females continue to comprise the majority of clients served: 73% versus 27% male. This is consistent with the target population of the federal Maternal and Child Health Block Grant: women, infants, and children. There has been a slight increase in the male percent of caseload, from 23% in 1996 to 27% in 2002.

Table 2 - All Agencies: Age Distribution of Clients (number & percent of caseload)

	1996	Percent of Caseload	2000	Percent of Caseload	2002	Percent of Caseload
Age 0-12	13,218	21%	14,112	19%	13,414	17%
Age 13-19	12,238	19%	13,727	18%	14,904	18%
Age 20-44	32,297	50%	34,366	46%	37,132	46%
Age 45-64	4,433	7%	8,715	12%	10,688	13%
Age over 64	2,167	3%	3,870	5%	4,623	6%

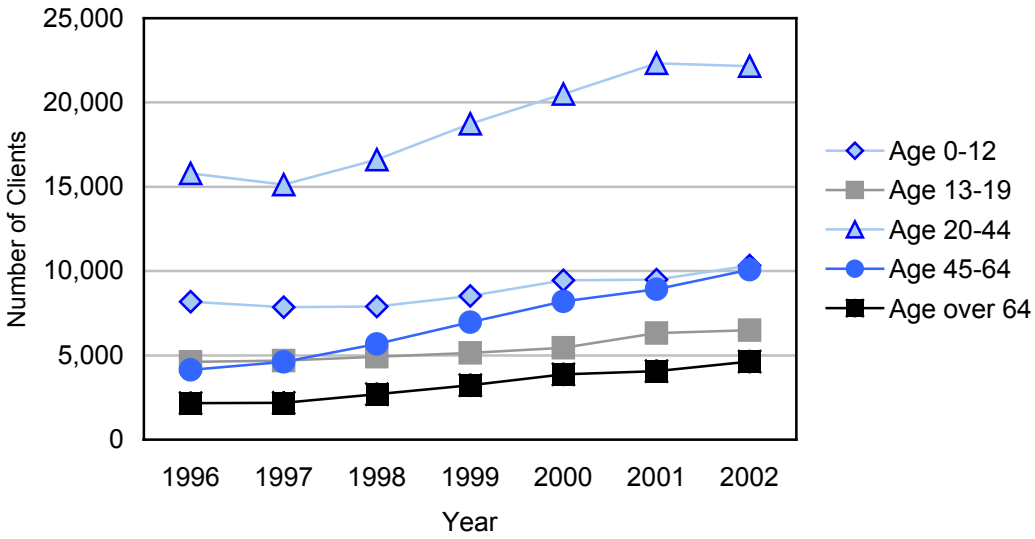
1. Community Health Centers

- There has been an increase in the number of clients served in every age category in Community Health Centers.
- The largest increases occurred in the older age groups: 143% in the group 45-64 years old, and 113% for those over age 64.
- The *percent of caseload*, for clients over the age of 44, has increased from 18% to 27%.

Table 3 - Community Health Centers: Changes in Age Distribution

	1996	2000	2002	Percent Change 1996-2002
Age 0-12	8,184	9,450	10,324	26%
Age 13-19	4,622	5,453	6,496	41%
Age 20-44	16,009	20,624	22,506	40%
Age 45-64	4,140	8,197	10,074	143%
Age over 64	2,167	3,870	4,623	113%

Graph 2 - Community Health Centers: Age Distribution



Several factors help to explain the increasing number of older clients served by the Community Health Centers. In 1996, seven of the eight agencies were relatively new. As the awareness of available primary care services - and the demand for these services - grew over the period of this report, agencies began to serve all age groups, not simply women of reproductive age and children. Additionally, between the 1990 census and the 2000 census, the number of individuals 45-64 grew by 47% in New Hampshire, more than any other age group during the 10-year period.

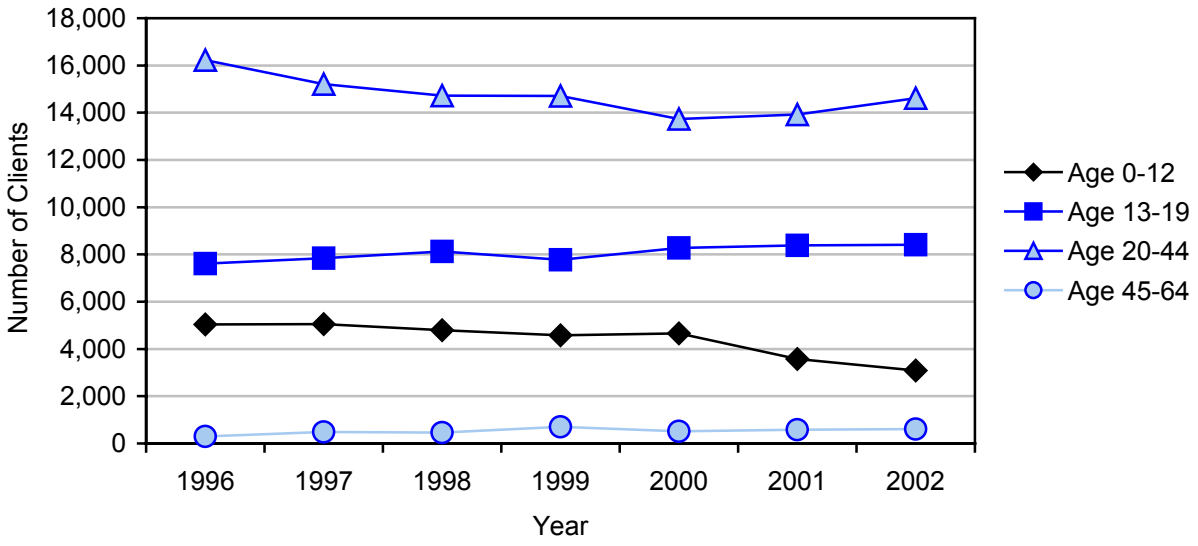
2. Categorical Agencies: Child Health, Prenatal, Family Planning

- The number of clients in the 13-19 and 45-64 age groups increased during the period.
- The number of clients in the 0-12 and 20-44 age groups decreased during the period.

Table 4 - Categorical Agencies: Changes in Age Distribution

	1996	2000	2002	Percent Change 1996-2002
Age 0-12	5,034	4,662	3,090	-39%
Age 13-19	7,616	8,274	8,408	10%
Age 20-44	16,288	13,742	14,626	-10%
Age 45-64	293	518	614	110%
Age over 64	0	0	0	No change

Graph 3 – Categorical Agencies: Age Distribution



The categorical agencies, as stated previously, provide one or more of the following services: child health care, prenatal care, or family planning services. Because of this, it is not as simple to analyze the changes in age distribution over the period. Nevertheless, the decrease in 0-12 year olds is, at least in part, due to some child health agencies discontinuing services as children newly covered by S-CHIP accessed care through private providers. The total number of children covered by S-CHIP increased from 828 in 1996 to 23,522 in 2001. Healthy Kids Gold processed 4,055 applications in 2002, an 11.8% increase in the number applying compared to 2001. Healthy Kids Silver enrolled 1,491 children, including those in the self-pay program, for an increase of 31.9% over 2001.

The decrease in individuals 20-44 through 2000 (and the increase from 2000 to 2002) coincides with the numbers served by agencies serving family planning clients during the same time-periods. The decrease in the number served through 2000 reflects level funding, increased costs, and the integration of family planning into primary care. The increase from 2000 to 2002 resulted from targeted federal funding to increase the number of family planning clients served.

The increase in 45-64 year-olds is large as a percentage (110%), but small in the actual number (321). The increase may reflect that "baby boomers" that have been receiving care from family planning agencies continue with these agencies for other women's health services after their reproductive years are over.

C. LOW-INCOME CLIENTS (<185% OF FEDERAL POVERTY LEVEL)

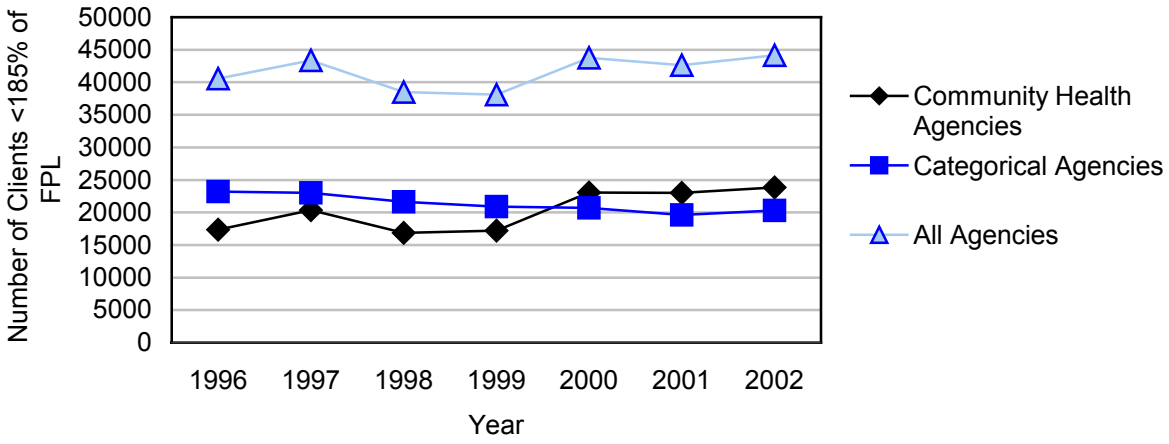
In 2002, over half of the clients served by the publicly-funded agencies lived in households with incomes less than 185% of the Federal Poverty Level (FPL).

- The *number* of low-income clients in 2002 was 44,142, an increase of 3,598 clients (9%) over 1996.
  - Community Health Centers served 6,485 more low-income clients in 2002 than in 1996, an increase of 37%.
  - Categorical agencies served 2,887 fewer low-income clients in 2002, a 12% decrease.
- In 2002, the low-income *percent of caseload* was 55%, compared to 63% of the caseload in 1996.
  - For Community Health Centers, the low-income percent of caseload was 44% in 2002, vs. 50% in 1996.
  - For categorical agencies, the low-income percent of caseload was 76% in 2002, vs. 79% in 1996.

Table 5 – Low-income Client Trends (number & percent of caseload)

	1996	2000	2002	Percent Change 1996-2002	% of total caseload, 1996	% of total caseload, 2000	% of total caseload, 2002
All agencies	40,544	43,763	44,142	9%	63%	57%	55%
CHCs	17,353	23,078	23,838	37%	50%	47%	44%
Categorical	23,191	20,685	20,304	-12%	79%	76%	76%

Graph 4 – Low-income Client Trends



The percent of people at less than *100%* of the FPL increased by 14% in New Hampshire, during the period between the 1990 census (69,104) and the 2000 census (78,530), possibly contributing to the increased numbers of low-income clients served by the agencies. According to agency feedback, the decline in the agencies' low-income *percent of caseload* is due to the agencies' efforts to serve more insured (and thus higher income) individuals, in order to maintain fiscal viability.

D. CLIENTS BY PAYMENT SOURCE

In 2002, 17% of the individuals served by agencies were Medicaid clients, and an additional 40% were without insurance of any kind.

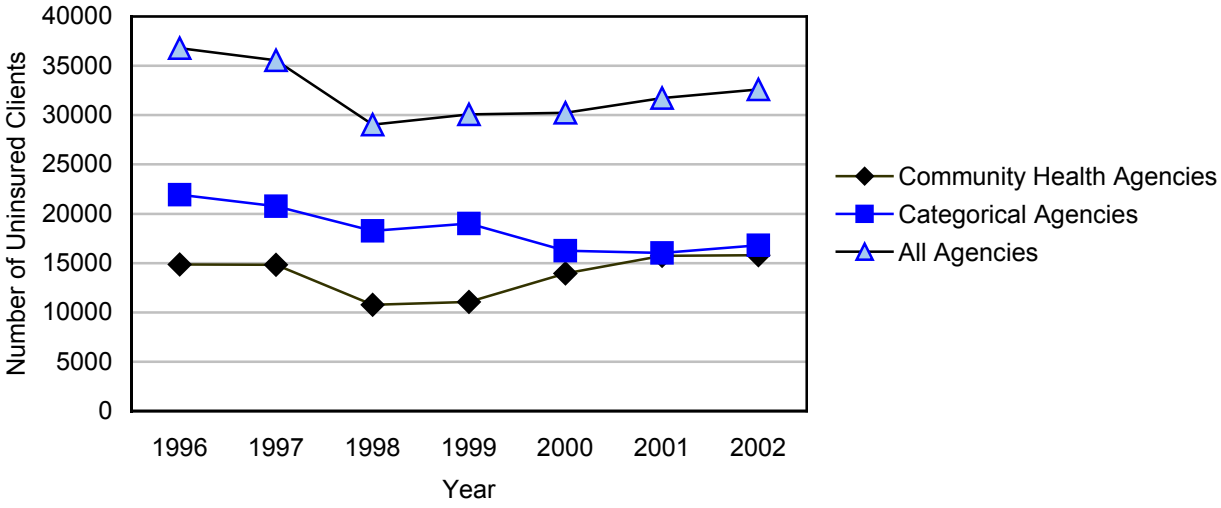
1. Uninsured

- The number of uninsured clients served by agencies in 2002 was 32,603, an 11% decrease from the 36,782 served in 1996.
- There was a 6% increase of uninsured clients served in Community Health Centers.
- There was a 23% decrease of uninsured clients served in the categorical agencies.
- The *percent of caseload* that was uninsured was 40% in 2002, a decline from 57% in 1996. Primary care and categorical agencies experienced similar declines in uninsured clients, *as a percent of caseload.*

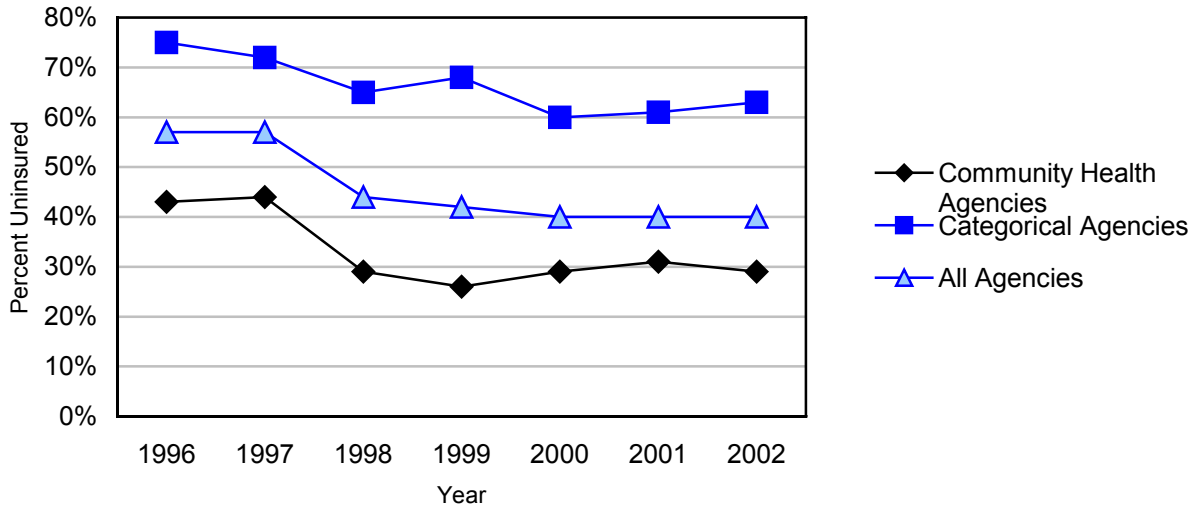
Table 6 - Uninsured Trends (number & percent of caseload)

	1996	2000	2002	Percent Change 1996-2002	% of total caseload, 1996	% of total caseload, 2000	% of total caseload, 2002
All agencies	36,782	30,073	32,603	-11%	57%	40%	40%
CHCs	14,853	13,963	15,809	6%	43%	29%	29%
Categorical	21,929	16,269	16,794	-23%	75%	60%	63%

Graph 5 - Number of Uninsured Clients



Graph 6 – Uninsured Percent of Caseload



The decline of uninsured clients served in the categorical agencies (and the small increase in Community Health Centers) may be due, in part, to an increase in children or pregnant teens enrolled in S-CHIP. While some of these individuals subsequently left MCH-funded agencies to be served by private providers, those who continued to be served by the agencies were reported as "insured" to the state. The agencies' increasing need to serve insured clients in order to maintain fiscal viability, and the strong 1990's/early 21st century economy – with its resulting jobs - may have been other factors. It is also true that in some areas, e.g. Coos County, the publicly funded Community Health Center has become an important source of primary care to the entire population, not just the poor and uninsured.

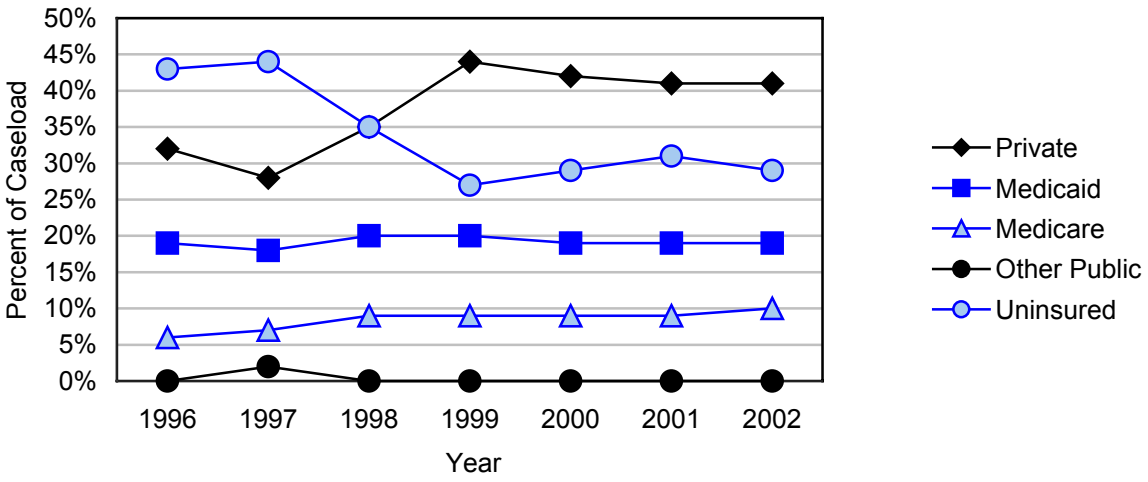
2. Medicaid

- During the period, the agencies consistently served between 12 and 14% of the total number of people in the state who are enrolled in Medicaid.
- The number of Medicaid clients served in agencies in 2002 was 14,087, a 16% increase from 12,104 in 1996. The number increased by 55% in Community Health Centers, and decreased by 30% in categorical agencies.
- In Community Health Centers, the *percent of caseload* whose primary source of payment was Medicaid was remarkably stable throughout most of the period.
- In categorical agencies, the *percent of caseload* whose primary source of payment was Medicaid decreased from 19% to 14%.

Table 7 - Medicaid Trends (number & percent of caseload)

	1996	2000	2002	Percent Change 1996-2002	% of total caseload, 1996	% of total caseload, 2000	% of total caseload, 2002
All agencies	12,104	14,196	14,087	16%	19%	19%	17%
CHCs	6,639	8,936	10,285	55%	19%	19%	19%
Categoricals	5,465	5,260	3,802	-30%	19%	19%	14%

Graph 7 - Community Health Centers: Payment Source for Services



The decline in the number and percent of caseload in the categorical agencies was likely due, in part, to children and pregnant teens leaving these agencies once enrolled in S-CHIP. In addition, children covered by Medicaid – and without dental insurance - were required to enroll in Medicaid managed care during the period, in order to obtain dental coverage. These children left the categorical agencies (well-child clinics), as they were required to see a primary care physician for their health care.

IV. CONCLUSIONS

The most significant conclusion from this report is that the agencies funded by the Maternal and Child Health Section continue to provide accessible and affordable health care to vulnerable clients. Approximately 5% of New Hampshire's total population, and approximately 13% of its Medicaid population, use these agencies as their source of health care services. In 2002, 17% of individuals served by the agencies were Medicaid clients, and an additional 40% were without insurance of any kind. In 1996 and 1997, seven agencies transitioned from categorical to primary care services. This change expanded the scope of services provided by these agencies, as well as the population served. While services were previously limited to family planning, well-child, and prenatal care, Community Health Centers deliver comprehensive preventive, acute, and chronic health care services to individuals of all ages, regardless of ability to pay. As such, they are critical safety-net providers. The DPHS remains committed to supporting MCH and Community Health Centers to provide these services. As of July 1, 2004, ten CHCs were funded by MCH to provide primary care services.

NOTES

- Graphs in this report use varying scales, adjusted for the data displayed. Therefore, caution should be used when comparing graphs.
- Data for Health First Family Care Center is estimated for 1996-2001.
- The names of some agencies changed during the time period of this report. In addition, some agencies ceased to exist and others started up during the period. Agencies listed in Appendix 1 were funded by MCH during fiscal year 2004 – and are currently required to provide UDS data.
- UDS Forms in Appendix 2 are only those used in preparing this report.

RESOURCES

- See Appendix 1 for a list of MCH-funded agencies in fiscal year 2004.
- For information on other state and national Maternal and Child Health programs, consult the USDHHS, Health Resources and Services Administration (HRSA) website: http://www.hrsa.gov/
- For additional information on New Hampshire MCH programs, consult the website at http://www.dhhs.state.nh.us/DHHS/MCH , or call 603-271-4517.

APPENDIX 1

MCH -FUNDED AGENCIES WHICH PROVIDE UDS DATA, FY 2004

Community Health Centers

Ammonoosuc Community Health Services - Littleton area

Avis Goodwin Community Health Center – Dover/Rochester area

Capital Region Family Health Center – Concord area

Coos County Family Health Services – Berlin area

Families First of the Greater Seacoast – Portsmouth area

Health First Family Care Center – Franklin area

Lamprey Health Care – Newmarket and Nashua areas

Manchester Community Health Center – Manchester area

Valley Regional Healthcare – Newport area

White Mountain Community Health Center – Conway area

Categorical Agencies

Community Action Program, Belknap/Merrimack Counties – Laconia area

Child Health Services – Manchester area

Dartmouth Hitchcock/Indian Stream – Colebrook area

Home Health and Hospice Care – Merrimack area

Lake Sunapee Home Care and Hospice – New London area

Planned Parenthood of Northern New England – central and southern New Hampshire

VNA at HCS – Keene area

VNA/Hospice of Southern Carroll County and Vicinity – Wolfeboro

Weeks Medical Center – Lancaster area

APPENDIX 2

UDS TABLES USED FOR ANALYSIS

Date Submitted: _____

Reporting Period: _____ 199__ through December 31, 199__

☐ Initial Submission ☐ Revision

USERS BY AGE AND GENDER
(UDS TABLE 3 PART A)

AGE GROUPS	MALE USERS	FEMALE USERS	TOTAL USERS
Under age 1			
Ages 1-4			
Ages 5-12			
Ages 13-14			
Ages 15-19			
Ages 20-24			
Ages 25-44			
Ages 45-64			
Ages 65-74			
Ages 75-84			
Age 85 and over			
Total Users			

Date Submitted: _____

Reporting Period: _____ 199___ through December 31, 199___

☐ Initial Submission ☐ Revision

SOCIOECONOMIC CHARACTERISTICS
(UDS TABLE 4)

CHARACTERISTIC	NUMBER OF USERS
Income as Percent of Poverty Level	
100% and below	
101-150%	
151-185%	
186-200%	
Over 200%	
Unknown	
TOTAL	
Principal Third Party Payment Source	
Medicaid	
Medicaid Capitated	
Medicare	
Other Capitated	
Other Public Insurance	
Private Insurance	
None/Uninsured	
TOTAL	